EXHIBIT B

PART 5 OF 5

Grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, such as the elimination of lifetime limits on essential health benefits. However, SCCAP is not intended to provide "essential health benefits" under the Affordable Care Act as described in FAQ #3 of the "FAQs About the Affordable Care Act Implementation Part IV" available at www.dol.gov/ebsa/faqs/faq-aca4.html. Therefore the $50,000 lifetime limit that each eligible child may receive under SCCAP continues to apply to all benefits under SCCAP. SCCAP will, however, comply with the other consumer protections that apply to grandfathered plans, such as extending cover-age to certain children regardless of their residency, their financial dependency on you, the availability of other coverage or their student, employment, tax dependency or marital status.

If you have questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status, please contact the health plan directly; contact information is available in the Contact Directory on NetBenefits (or on your Health Plan Detail Sheets if you receive print enrollment materials by mail). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans.

IBM Adoption Assistance

Adoption Assistance Program for Retirees through December 31 2015

ABOUT THE IBM ADOPTION ASSISTANCE PROGRAM

Through the Adoption Assistance Plan, IBM provides some financial assistance towards expenses incurred in the adoption of minor children.

Who's Eligible

You're eligible if you are a retiree and the child is placed in your home on or before December 31, 2015. Effective January 1, 2016, this benefit will no longer be available to retirees. Reimbursement claims for placements made prior to December 31, 2015, must be submitted no later than December 31 of the year following the year in which the placement occurred; otherwise no benefit will be payable.

Note: If you and your spouse are both IBM Retirees (or your spouse is an IBM employee), only one of you may submit a claim. The plan provides reimbursement for each adopted child per family, not per retiree/employee.

How the Program Works

The IBM Adoption Assistance Program provides some financial assistance toward expenses incurred in the adoption of minor children. For eligibility under the program, the child must be below the age of majority (as defined by the law of the state in which the adoption occurs) on the date of placement. The Adoption Assistance Program covers the adoption of:

- Unrelated minor children
- Foreign minor children
- Minor children of relatives
- Minor stepchildren
- Minor twins or multiple children

You will be reimbursed 80% of the eligible charges which you are required to pay, up to a maximum benefit of $2,500 for each adoption per family. Benefits will be paid once the child has been placed with the adoptive parent(s). A child is considered to be "placed" when the adoptive parent(s) receives legal custody of the child as a step in the adoption process. This will not necessarily coincide with the time the child physically arrives at the adoptive family's home; nor will it necessarily coincide with the date of final adoption, which may be some time after the child has been living with the adopting parent(s).

WHAT'S COVERED UNDER THE PROGRAM

- Adoption agency fees (application fee, immigration fee, immunization fee, translation fee, Home Study Fee required by the state, etc.)
- Placement fees
- Lawyer's fees and other required legal fees
- Hospital expenses (while both the birth mother and infant are in the hospital)
- Temporary foster care charges (immediately preceding placement of the child with the adopting family)

Exclusions: What's Not Covered Under the Program

- Travel expenses for the child or adoptive parent(s)
- Voluntary donations or contributions
- Legal fees incurred to obtain guardianship or custody of one's own child
- Personal items for the child such as clothing, shoes, crib or other furniture, meal expenses, etc. (generally incurred if there is an extended period in a foster home prior to the adoption)

How to Apply for Reimbursement

For information or to receive an IBM Adoption Assistance Program claim form, contact the IBM Employee Services Center (ESC). Claim forms are also available on NetBenefits or from the Acclaris website.

You may submit your claim form as soon as you take legal custody (in anticipation of adopting) of the child(ren), which may, but may not necessarily, coincide with the date the child(ren) is placed with you. Submit one claim form for each adopted child.

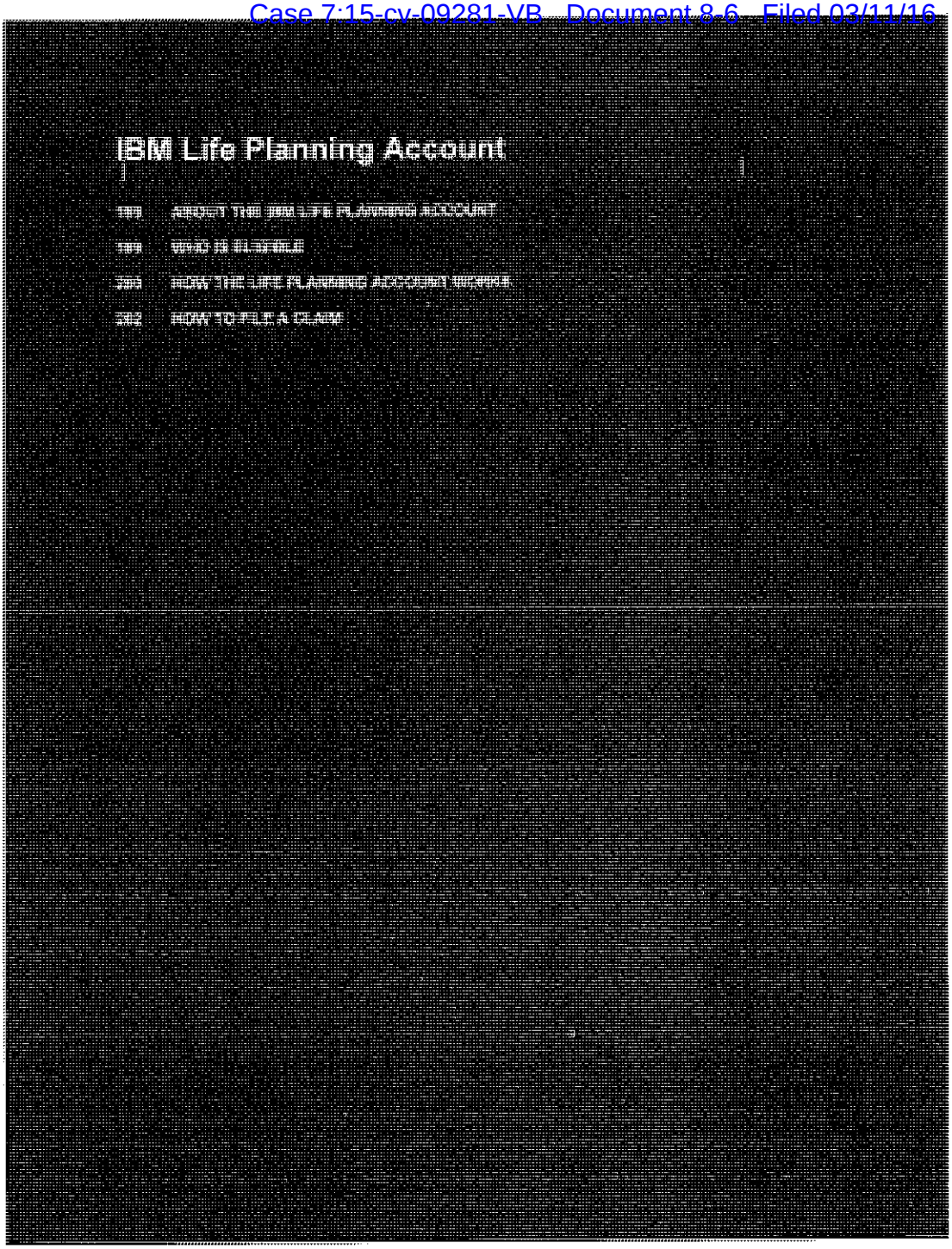
You and your spouse are both IBM retirees (or your spouse is an IBM retiree), only one of you can submit an Adoption Assistance claim. The program provides reimbursement for each adopted child per family, not per retiree/employee.

To file a claim:

- Complete the claim form and attach all itemized bills and supporting documentation (including proof of payment) as well as a copy of a document from a third party, such as an adoption agency/service or court showing the placement date. For embryo adoption, submit these to Acclaris at the address on the form.
- All claims and supporting documents must be received by Acclaris no later than December 31st of the following year in which the placement of legal custody occurred; otherwise, there will be no benefit payable.
- Reimbursement of eligible claims will be provided monthly to active employees via their pay; to other eligible individuals (employees on leave of absence with benefits or MDIP/LTD) via check mailed directly to the home address. Actual payment of claims will be made following your receipt of an Explanation of Benefits (EOB) statement from Acclaris. All questions regarding claim payments should be directed to Accla

(1) The IBM Adoption Assistance Program is not a qualified plan for purposes of the Internal Revenue Code. All adoption expenses which are reimbursed under the program are reported to the IRS by IBM as compensation subject to the appropriate federal, state and local withholding taxes. Therefore, when you receive your W-2 for the previous tax year, box 13 is not populated with a "T" because it is taxable income.

(2) Effective January 1, 1997, IRS Publication 968 on Tax Benefits for Adoption (available from the IRS, public libraries and on the Internet [www.irs.ustreas.gov]), provides information on how you can receive tax-favored treatment for qualified adoption expenses. You may want to consult your personal tax advisor prior to incurring adoption expenses and submitting for reimbursement under IBM's Adoption Assistance Program.


IBM Life Planning Account

IBM Life Planning Account

ABOUT THE IBM LIFE PLANNING ACCOUNT

Your health and finances are two important aspects of your life. To encourage you to take care of yourself today and plan for your changing future needs, the Life Planning Account provides financial assistance of up to $250 per eligible retiree annually in taxable re-imbursement for eligible expenses in the following areas:

- IBM Long-Term Care Insurance Program with John Hancock Life Insurance Company (USA)
- Health education and fitness
- Bone marrow typing and registration
- Personal Financial Planning

LIFE PLANNING ACCOUNT ADMINISTRATOR

The administrator for the Life Planning Account is Acclaris.
Customer Service Availability

Acclaris representatives are available to assist you with claim questions Monday through Friday from 8 a.m. to 8 p.m. Eastern Time

You can reach an Acclaris representative at 888-880-2775 or online at www.acclarisonline.com.

If you have any questions about the Life Planning Account in general, or to verify if an expense is eligible for reimbursement, contact the ESC.

WHO IS ELIGIBLE

The following individuals are eligible for the Life Planning Account:

- Employees who retired on or before December 31, 2003.
- Employees receiving Long-Term Disability (LTD) benefits who were covered by the LTD Plan on or before December 31, 2003.
- Surviving spouses/domestic partners who were eligible for more than one year of survivor's medical benefits who were spouses/domestic partners of employees who retired (or died when retirement eligible) on or before December 31, 2003. (See "Eligibility" in the Personal Benefits Program section.)

References to "retiree" in this program description refer to a retiree, former employee, employee on Long-Term Disability or MDIP who is eligible to enroll in medical benefits under the IBM Medical and Dental Benefits Plan for Retired Employees, as described in the eligibility criteria in the Administrative Information section.

If you and your spouse/domestic partner are each eligible for IBM benefits coverage in your own right, you will each be eligible to receive a Life Planning Account for reimbursement of eligible expenses.

HOW THE LIFE PLANNING ACCOUNT WORKS

The Life Planning Account is administered on a calendar-year basis. An expense is considered incurred on the date the related service was rendered or the course was completed. In the case of fitness or weight control programs, the entire expense is considered to be incurred when the last session is completed (8 consecutive weeks). In the case of personal financial planning, the expense is considered incurred on the date that the service is billed.

IBM Long-Term Care Insurance Premiums

Plan long-term care is an integral part of your personal financial plan. The IBM Long-Term Care Insurance Program, underwritten by John Hancock Life Insurance Company (USA), can provide protection against the expenses of nursing home care, home health care, adult day care and respite care. These are expenses not normally covered by the IBM Plan. The Life Planning Account will reimburse up to 20% of the Long-Term Care premium costs for you and/or your spouse, up to the $250 annual maximum. See the "IBM Long-Term Care Insurance Program" section for additional information.

Health Education and Fitness

To help you achieve or maintain a healthy lifestyle, the Life Planning Account will provide financial assistance toward various formal courses, classes, seminars and programs that promote good health, including nutrition, exercise classes and smoking cessation classes. Eligible family members, as defined in "Eligibility" in the Personal Benefits Program section, can also make use of your Life Planning Account for health education and fitness programs, whether or not they are enrolled in IBM medical coverage.

Eligible Health and Fitness Expenses

There is no specific list of eligible courses under the Life Planning Account. It is IBM's intention to provide reimbursement through the Account for classes and programs that allow you to learn about ways to maintain or improve your health in the long term. To determine if a class or program is eligible for reimbursement under the Account, call the ESC. Reimbursements for eligible classes or programs are paid after you have completed the eight consecutive weeks of participation and provided the required documentation.

Charges for the following types of programs are eligible for financial assistance under the provisions of the Life Planning Account:

- F —Classes or programs designed to help you stay fit. Aerobics, weight training and yoga are only a few examples of fitness programs that can be part of your fitness future. For these expenses to be eligible for reimbursement you must participate for at least eight consecutive weeks.
- *Weight Control*— Programs or courses that help you lose weight and change your eating habits. For these expenses to be eligible for reimbursement you must participate for at least eight consecutive weeks.
- *N*
- *Stress Management*— Programs such as stress management seminars and courses for relaxation techniques.
- *Smoking Cessation*— Classes that help you quit smoking through behavior modification. Hypnosis, nicotine patches and gum will not be reimbursed.
- *C* lp you identify cancer risks and change your behavior to minimize those risks.

- *Cardiovascular Health* — P
- Substance Abuse Prevention — education about drug and alcohol abuse. Treatment programs are not eligible.

Examples of Courses and Programs That Are Not Eligible

- Recreational activities and lessons such as golf, tennis, swimming, dance, horseback riding, racquet-ball, squash or handball or gymnastics.
- Programs involving competition or physical contact or those that are considered dangerous, such as Karate, Tae Kwon-Do or self-defense courses and boxing.
- Medical treatments, cardiac rehabilitation, examinations (these may be eligible for IBM medical benefits) or education (e.g., Lamaze).
- Personal trainers, dieticians, nutritionists, physical therapists or massage therapists.
- Equipment, videos, books, software or cassettes, other than those approved by IBM and communicated to employees as eligible for financial assistance.
- Vitamins, mineral supplements, foods or food supplements.
- Driver education/improvement courses.
- Memberships, entrance fees or clothing.

Although IBM does not intend to reimburse membership fees, the Company does recognize that some facilities require membership fees only for participation. In these instances, the Life Planning Ac-count may be applied toward the membership and eligible expenses; however, you will only be reimbursed for the membership fee after you have completed eight consecutive weeks of participation and provided the required documentation.

Bone Marrow Typing and Registration

IBM will reimburse you for the cost, up to the $250 annual maximum, of tissue typing a blood sample for marrow donation. For more information about marrow donation you may:

- Call National Marrow Donor Program (NMDP) at 800-654-1247
- Visit the NMDP web site at www.marrow.org.
- Call the Care Coordinator for your health plan

Expenses associated with the actual donation of bone marrow to an individual may be covered by the recipient's insurance coverage or NMDP. In the absence of such coverage, associated charges may be eligible for consideration under the IBM Low, Medium and High Deductible PPO, IBM Medical Supplement, Medical/Prescription Drug Supplement, Medical/Prescription Drug Supplement Plus plans and Medicare Supplement options.

Personal Financial Planning

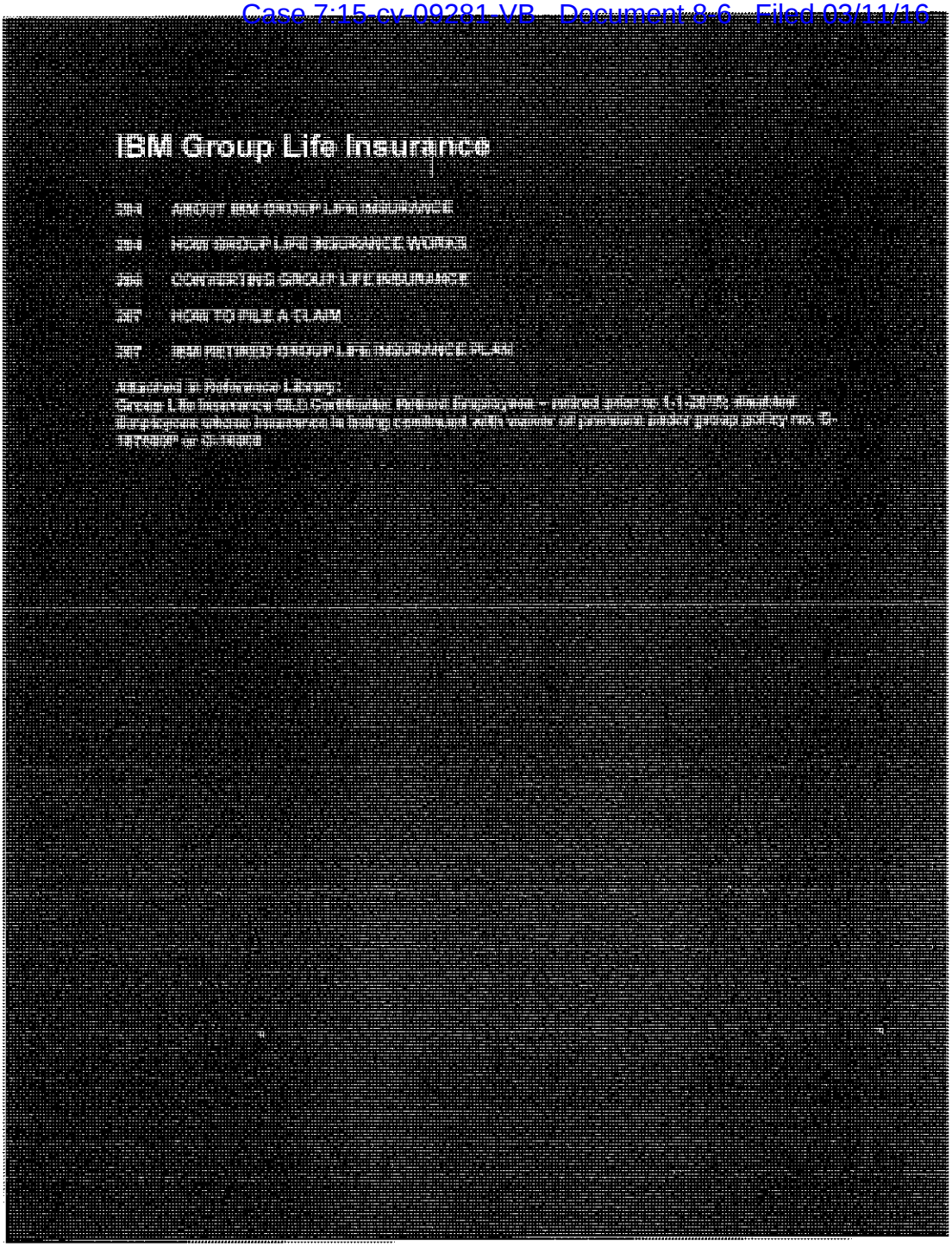
Whether you are balancing your checkbook or establishing an educational fund for your children, financial planning can be demanding. The Life Planning Account offers financial assistance for selected services provided by a certified financial planner or chartered financial consultant. You can work with a professional to create a personalized financial plan that takes into coosideration your IBM benefits.

HOW TO FILE A CLAIM

For information or to receive a Life Planning Account claim form, contact the ESC. Claim forms are also available on NetBenefits. Upon completion of an eligible health or fitness course or program, send a completed claim form to Acclaris at the address on the form. Make sure you attach the following to the claim form:

- The invoice from the provider with the name of recipient, services provided, beginning and end dates, and charges for services provided.
- A canceled check, credit card receipt or cash payment receipt (a cash payment receipt must be signed by the provider as proof of payment).
- For reimbursement of the IBM Long-Term Care Insurance premium, attach the statement sent to you by John Hancock Life Insurance Company (USA) each January for the preceding year.
- For reimbursement of eligible bone marrow typing and registration, attach the invoice from the provider showing the services provided, the date of service and the charges for the service.
- For reimbursement on Personal Financial Planning services, attach a copy of the bill/invoice from a certified financial planner or chartered financial consultant, along with proof of payment.

Claims must be received by Acclaris no later than April 30th of the year after the year in which the charges were incurred, otherwise no benefit will be paid. Please note this is a different reimbursement schedule than the IBM medical plans. Claims for your account will be subject to applicable federal, state and local taxes.


IBM Group Life Insurance

IBM Group Life Insurance

ABOUT IBM GROUP LIFE INSURANCE

To help supplement your personal life insurance program, IBM provides Group Life Insurance. IBM retirees and other eligible former employees (see "Who Is Eligible" below) are eligible for post-employment coverage under the Group Life Insurance Plan (GLI), with some changes.

Who Is Eligible

The following individuals are eligible for the IBM Group Life Insurance Program:

- Employees who retired prior to January 1, 2015 under the terms of the prior IBM Retirement Plan.
- Former employees who were not participants in the prior IBM Retirement Plan at separation but who separated from IBM prior to January 1, 2015 after satisfying the prior IBM Retirement Plan criteria:
  - 30 years of service or
  - Age 55 with at least 15 years of service or
  - Age 62 with at least 5 years of service or
  - Age 65 with at least 1 year of service

References to "retiree" in this program description refer to a retiree, former employee, employee on

Long-Term Disability or MDIP who is eligible to enroll in medical benefits under the IBM Benefits Plan for Retired Employees, as described in "Eligibility" in the Personal Benefits Program section of this summary plan description.

Employees hired on or after January 1, 2004 and those that separate from IBM on or after January 1, 2015 are not eligible for post-employment coverage under the Group Life Insurance Plan.

HOW GROUP LIFE INSURANCE WORKS

IBM Group Life Insurance coverage as an active employee ceases after you terminate employment with IBM (via retirement or otherwise). The amount of life insurance coverage you are eligible for depends on your age.

Note: For employees hired before January 1, 2004, who remain continuously employed by IBM and re-tire from IBM prior to January 1, 2015 (as defined under the IBM Personal Pension Plan), GLI coverage during retirement (until age 65) is equal to one-half of the amount that was in effect immediately prior to retirement, to a maxi-mum of $25,000. Once you reach age 65 (either at or during retirement), GLI coverage is then reduced to $5,000 and will remain at that level throughout the retirement period.

Employees hired on or after January 1, 2004 and those that separate from IBM on or after January 1, 2015 are not eligible for GLI coverage after they terminate their employment with IBM even if they retire (as defined under the IBM Personal Pension Plan).

IBM GROUP LIFE INSURANCE ADMINISTRATOR

The administrator for the IBM Group Life Insurance Program is Prudential.

You can reach a Prudential representative at 800-524-0542, week-days from 8 a.m. to 8 p.m. Eastern Time.

If You Are Age 65 or Older

If you retire (or otherwise terminate employment with eligibility for GLI coverage) at or after age 65 prior to January 1, 2015, your life insurance coverage is reduced to $5,000.

If You Are Younger Than Age 65

If you retire (or otherwise terminate employment with eligibility for GLI coverage) before age 65, prior to January 1, 2015, your life insurance coverage will be equal to 50% of the amount that was in effect immediately prior to your retirement/termination, up to a maximum of $25,000. When you reach age 65, your insurance will then be reduced to $5,000 and remain at that level.

Eligibility for the accelerated death benefit ends with your date of retirement or other termination from IBM.

Designating a Beneficiary

You can choose your beneficiary and change your beneficiary at any time by completing the beneficiary designation form, which is available from the ESC. If you make a change, your new beneficiary designation becomes effective when the completed form is approved by the ESC.

In the event a beneficiary form is received after the death of the retiree, if Prudential has already paid out the GLI benefit, this beneficiary change will not be valid.

If you do not name a beneficiary, or if your beneficiary dies before you and a new beneficiary is not chosen, payments will be made to your spouse, if living; otherwise in equal shares to your surviving children or, if none survives, to your surviving parents, equally. If no spouse, child or parent is then living, payments are made to the executors or administrators of your estate.

It is important to remember that if a retiree designates his or her spouse as the beneficiary, and the employee and spouse are later divorced, this former spouse will remain the retiree's beneficiary until and unless the retiree makes a change.

Be sure you review your copy of your beneficiary designation periodically to make sure your choice is current. If you are in doubt as to who your beneficiary is, submit a new Designation of Beneficiary form. The most recent form received by the IBM Employee Services Center will always be used to determine designated beneficiaries (except certain forms received after death, as explained above).

If you wish to receive verification of beneficiary information, you must send either a written and signed request or an e-mail to the ESC. Your request (whether written or e-mail) should include your return address, employee serial number, Social Security number and signature. The IBM ESC address for written beneficiary verification is:

IBM Employee Services Center
P.O. Box 5000
Cincinnati, OH 45273-8637

E-mail requests should be sent to pension@us.ibm.com

Form of Benefit Payment (Mode of Settlement)

You may choose a mode of settlement by making a request to Prudential. If you have not chosen a mode of settlement prior to your death, your beneficiary may enter into an agreement with Prudential as to how the group life insurance benefits will be paid.

Benefit payment options include:

- Income payments with interest for a specified number of years.
- Income payments with interest for the beneficiary's lifetime.
- Income payments of a stated amount until the fund of principal and interest is used up.
- A lump-sum payment.
- Leave the funds with the insurance company with the interest paid as a regular income — you can select another settlement option at a later time.

The insurance proceeds may also be paid under more than one option (for example, partly in a lump-sum amount with the balance in monthly installments).

If you are interested in pre-designating one of these modes of settlement, you will need to contact Prudential directly at 800-524-0542. Representatives are available weekdays from 8 a.m. to 8 p.m. Eastern Time.

CONVERTING GROUP LIFE INSURANCE

Whenever your life insurance is reduced or terminates (for example, because of retirement or other termination of employment with the Company), you can convert a portion or all of the amount discontinued into any one of the forms usually issued by the insurance company, except term insurance in excess of one year or any policy containing disability or other supplementary benefits.

The period of time during which the conversion must be made varies with the situation:

- If an employee terminates employment without eligibility for post-employment GLI coverage (see above) or goes on a leave of absence without benefits, then life insurance terminates on the date of the employee's termination and is followed by a 31-day period during which the employee can convert the amount of insurance under this policy. Should the employee die during this 31-day period, the insurance that would have been paid prior to termination would be paid to the beneficiary.
- If an employee other than one who has been on a Retirement Bridge Leave of Absence without benefits has a reduction in insurance due to retirement or other termination with eligibility for continued (but reduced) coverage, then the reduction occurs 31 days following retirement/termination; following this 31-day period, there is a 31-day conversion period during which the employee may elect to convert the amount of the reduction. Should the employee die during the 62 days following retirement/ termination, the full amount of insurance which was in force prior to the event of death will be paid to the beneficiary.
- If a retiree (or other eligible former employee) has a reduction in insurance for reaching age 65, then the reduction occurs 31 days after the last work day of the month in which the retiree reaches age 65. Following this 31-day period, there is a 31-day conversion period during which the retiree may elect to convert the amount of the reduction. Should a retiree die during this period, maximum 92 days, the full amount of insurance which was in force prior to the event of death would be paid to the beneficiary.

If you wish to exercise the conversion privilege available under this policy, you must do so within 31 days of the date your insurance ends or is reduced (see above). The individual policy will take effect when the 31-day period ends.

To initiate the conversion, you should contact any local Prudential office or agent, who has information on how to convert your insurance. IBM cannot give you rate information or process your conversion. You will need to complete a GLI Conversion Notice, which may be obtained by calling the ESC. For general information about converting, you may call Prudential at 877-889-2070, weekdays from 8 am to 8 pm Eastern Time.

As part of the conversion process, you may apply for an individually-underwritten policy at the same time. If you apply for such a policy and show satisfactory evidence of good health, it is possible that you may qualify for preferred rates. The process by which one applies for a conversion policy and an individually-underwritten policy at the same time is called the Dual Application Process. Under this process, if the evidence of good health is satisfactory, you will be issued the individually-underwritten policy; otherwise, you will automatically be issued a conversion policy. The advantages of an individually-underwritten policy include the possibility of more favorable rates, a larger selection of plans and the option, at certain ages, of an Accidental Death Benefit in addition to the usual death benefits.

It is important to note, however, that the conversion policy must be issued and delivered within the United States. If you live outside the United States (this includes Puerto Rico, but not the Virgin Islands or Guam) and wish to convert an individual policy, you must either:

- Physically apply for and receive the policy in the United States or
- Designate a person in the United States with the Power of Attorney to apply for the conversion on your behalf.

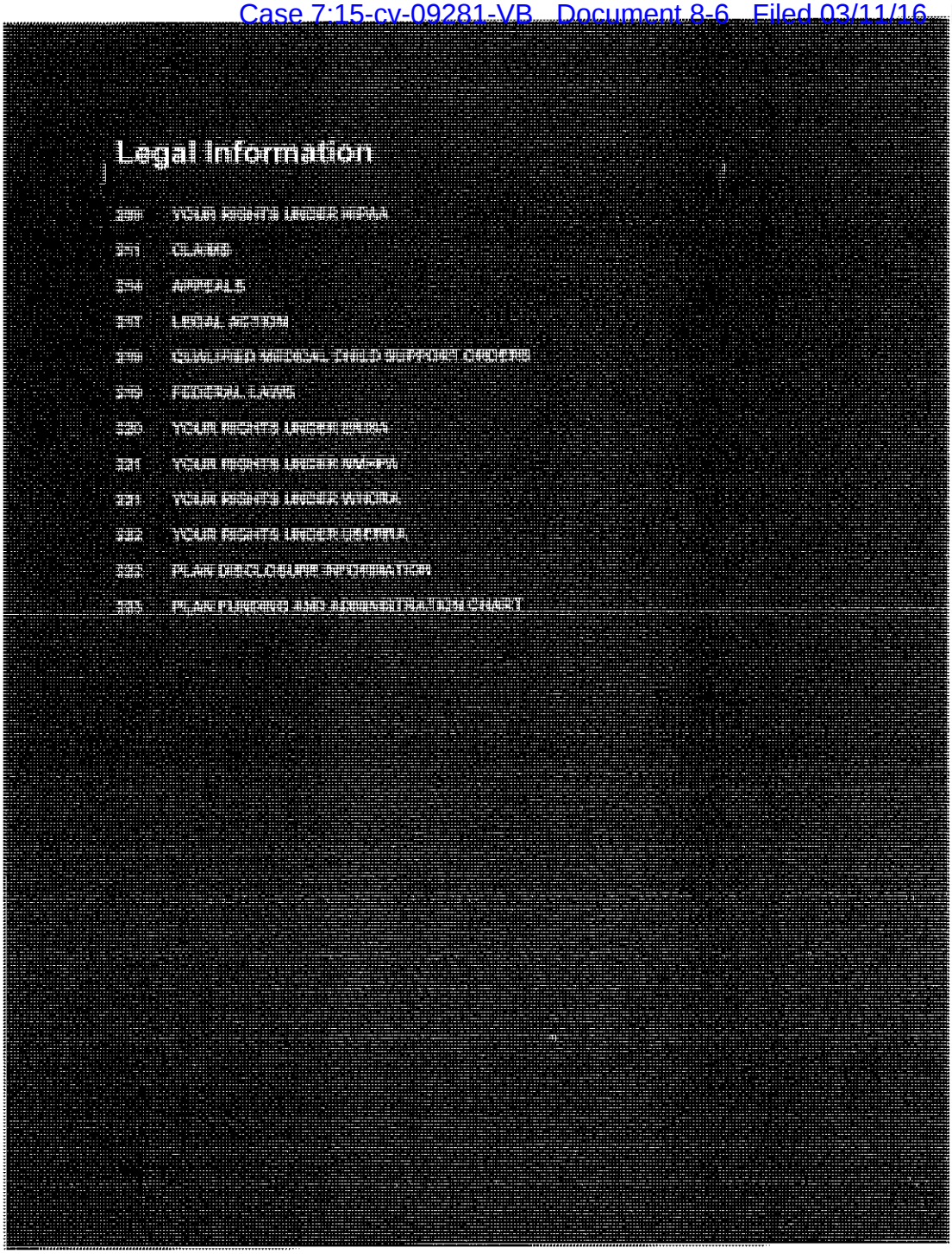
HOW TO FILE A CLAIM

Your beneficiary will receive from IBM the necessary forms and instructions for filing a claim, including the mode of payment of the life insurance. Upon receipt of the completed forms and documentation, IBM will forward the insurance claim to the insurance carrier for processing and payment of the life insurance proceeds. If the life insurance beneficiary is legally incapable of handling his or her affairs, payments will be made to the responsible entity appointed by the courts.

This is only a summary of the IBM Group Life Insurance Plan and does not cover all the details. In the event a claim is made, the actual wording of the policy will govern.

IBM RETIRED REGULAR PART-TIME EMPLOYEE GROUP LIFE INSURANCE PLAN

The provisions and coverage described in this section apply to regular part-time employees who retire or otherwise terminate employment with eligibility for IBM Group Life Insurance (see "Who Is Eligible"), except that the benefit is 75% of the dollar amounts stated, for those who retired/terminated on or before December 31, 1996. For those part-time employees who retire/terminate after December 31, 1996, the provisions and coverage described in this section apply and there is no reduction of the dollar amounts stated.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Legal Information

YOUR RIGHTS UNDER HIPAA

The Department of Health and Human Services has issued federal regulations regarding the privacy of individual health records. These regulations are part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The purposes of this law (referred to as the "Privacy Rule") are to standardize and safeguard the transmission of protected health information, to protect the privacy of individual health information and to allow individuals to access their medical records.

The HIPAA Privacy Rule applies to the IBM Benefits Plan for Retired Employees (referred to as the "Plan"), including the Plan's medical, dental, vision and employee assistance program coverages. The Privacy Rule was effective as of April 14, 2003.

Health Information Protected by the HIPAA Privacy Rule

The HIPAA Privacy Rule applies to "Protected Health Information" (PHI). PHI is individually-identifiable health information that is created or received as part of administering the Plan. PHI includes information that (1) identifies, or can be used to identify, you, (2) is created or received by a health care provider, health plan, or employer, and (3) relates to your past, present and future physical or mental condition, and the provision of health care and payment for that care.

Uses and Disclosures of Protected Health Information by the Plan

The Plan may use or disclose PHI for purposes of treatment, payment, health care operations or as authorized by you. Information may also be disclosed in order to comply with federal, state or local law and to avert a safety threat to you or the public. When protected information is used or disclosed, even for purposes of treatment, payment or health care operations, only the minimum amount of information determined necessary to achieve the task will be used or disclosed.

Your Rights Under the HIPAA Privacy Rule

- Your protected health information will be kept private and will not be used or disclosed other than as permitted under the HIPAA Privacy Rule or as required by law.
- Your protected health information will not be used for unrelated purposes, such as making employment-related decisions or decisions related to other IBM benefit plans, unless specifically authorized by you or as required by law. (You may limit or revoke an authorization at a later time.)
- You have the right to inspect and obtain a copy of certain designated medical records, if such records are maintained by the Plan, and to request changes to those records.
- You have the right to request a listing of the Plan's uses and disclosures of your PHI (other than for purposes of treatment, payment and healthcare operations as described above).
- You have the right to request a restriction or limitation on how the Plan can use or disclose your private medical information for purposes of treatment, payment or health care operations. The Plan will consider but is not required to agree to your request.
- You have the right to request that the Plan's communications with you about your PHI are made in a certain way or at a certain location if your request states that communication in another manner may endanger you. The Plan will accommodate reasonable requests.
- You have the right to be notified if the plan discovers a breach of unsecured PHI.

If you wish to request an opportunity to inspect or obtain a copy of your PHI, an amendment of your PHI, a listing of the Plan's uses and disclosures of your PHI, a restriction or limitation on uses and disclosures of your PHI or a particular means of communication, and your request pertains to PHI maintained by the Plan at the ESC, submit your request in writing to:

IBM Employee Service Center,
PO Box 770003
Cincinnati OH 45277-1060

For requests pertaining to PHI maintained by a health plan for a medical, dental, vision or other option within the Plan, submit your request in writing to the applicable health plan(s) at their address listed in "Plan Funding and Administration Chart" later in this section.

IBM's Responsibilities Under the HIPAA Privacy Rule

The Plan may disclose PHI to IBM, as the Plan Sponsor, for purposes of administering the Plan. In order to receive this information, IBM must certify to the Pla l: (a) comply with the HIPAA Privacy Rule, (b) only use and disclose PHI as required by law or for the permitted purposes described un the previous page, (c) only use and disclose the minimum amount of information determined necessary to achieve the task and (d) report to the Plan any violations of these requirements.

Any disclosure of PHI by the Plan to IBM will be limited to only those IBM employees who are directly involved in the administration of the Plan (which may include employees in the Human Resources/ Benefits, Internal Audit/Business Controls and Legal f lity for matters relating to Plan administration) and to those subcontractors of IBM who have been retained for purposes of administering the Plan (such as a health Plan Administrator for one of the Plan options). Unless authorized by you or required by law, these employees and subcontractors will only use or disclose PHI for purposes related to treatment, payment or health care operations under the Plan and will implement reasonable and appropriate security measures to protect the information. Any employee who uses or discloses PHI for any other purpose will be subject to disciplinary action. The Plan will notify you in the event of any breach involving unsecured PHI. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

Additionally, IBM has agreed to: (a) make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule, and (b) if feasible, return or destroy all PHI received from the Plan and retain no copies of PHI when it is no longer needed or, if not feasible to return or destroy PHI, to safeguard and limit the use and disclosure of the PHI as required by law and (c) implement administrative, physical, and technical safeguards (within the meaning of 45 C.F.R. § 164.304) that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI (as defined in 45 C.F.R. § 160.103) that IBM creates, receives, maintains, or transmits on behalf of the Plan.

Notification of a Breach

We are required to notify you in the event that we (or one of our business associates providing services to the Plan) discover a breach of your unsecured PHI, as defined by HIPAA.

Authorizations

Other uses or disclosures of your PHI not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Concerns About the Handling of Your Protected Health Information

If you believe your rights under the HIPAA Privacy Rule have been violated, you may file a written complaint with the Plan or with the Department of Health and Human Services.

The plan has designated at Chief Privacy Officer at IBM, who is responsible for developing, communicating and enforcing the necessary procedures for ensuring the privacy of PHI. The IBM Chief Privacy Officer is the Plan's first point of contact for handling a complaint. The IBM Chief Privacy Officer will investigate the details of your complaint, and will respond to you with the results of the investigation. To file a complaint with the Plan, please contact: IBM Chief Privacy Officer 1 New Orchard Road, Armonk NY 10504 Attn: HIPAA Privacy. All complaints must be submitted in writing. You will not be penalized or otherwise retaliated against for filing a complaint.

You may also contact the Department of Health and Human Services at the Office of Civil Rights for the region where the alleged violation occurred. Contact information for regional offices of the Office of Civil Rights is available at www.hhs.gov/ocr/office/about/rgn-hqaddress.html.

Additional Information

A complete description of your rights under the HIPAA Privacy Rule, including examples of permitted uses and disclosures of PHI, can be found in the Plan's Health Information Privacy Notice. The Notice was distributed to all retirees covered by the Plan on October 11, 2013 (or upon becoming eligible, whichever is later). A copy of the Notice is available on NetBenefits or by calling the ESC.

CLAIMS

In order to receive benefits under the plans described in this book, you or your health care provider must submit a claim to the Claims Administrator for the applicable health plan under which you are seeking a benefit. For the IBM Benefits Plan for Retired Employees, you must submit your claim to the Claims Administrator for the particular medical, vision, dental option or HRA under which you are seeking a benefit. For ease of discussion in this section, these plan options are also referred to as "plans." For purposes of this section, a "claim" means (1) a request for a plan to pay benefits covered under the plan or (2) a request for the plan to reinstate your coverage after a rescission of coverage (i.e., a retroactive cancellation of your coverage for reasons other than your failure to timely pay contributions toward the cost of coverage). Requests for a determination regarding whether you or another person are eligible to participate in a plan must be submitted to the Plan Administrator in accordance with the procedures described in "Eligibility".

Each plan described in this book provides an internal claim and appeal process administered by the Claims Administrator and Appeals Administrator for the particular plan and the IBM Plan Administrator.

Claims for Non-Health Benefits

For claims for benefits that are not health benefits, unless special circumstances require an extension of time for processing the claim, the Claims Administrator will notify you or your authorized representative of its decision within 90 days after the Claims Administrator receives the claim. If an extension is necessary, the Claims Administrator will notify you or your authorized representative before the expiration of the initial 90-day period. The notice will indicate the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. In no event may the extension exceed 90 days from the end of the initial period.
You or your authorized representative may file a written appeal with the Appeals Administrator for the plan within 60 days after receiving notice of a denied claim for non-health benefits. (See "Plan Funding and Administration Chart" for the plans' appeals addresses.) Appeals received after this time will not be eligible for review under the internal appeals procedures.

"Post-Service" Health Claims

Post-service health claims are claims for health benefits that did not require advance approval f
lan.

The Claims Administrator will provide notice of the plan's final decision within 30 days after receipt of a post-service health claim. However, if the Claims Administrator needs more time to make a determination due to matters beyond its control, the Claims Administrator will notify you or your representative of the need for additional time within 30 days after receiving the claim. This notice will include the reason for the extension and the date a determination can be expected, which will be no more than 45 days after receipt of the claim. If more time is needed because necessary information is missing from the claim, the notice will also specify what information is needed, and you or your representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and will resume on the date you or your representative responds to the notice.

You or your authorized representative may file a written appeal with the Appeals Administrator for the plan within 180 days after receiving notice of a denied post-service health claim. (See "Plan Funding and Administration Chart" for the plans' appeals addresses.) Appeals received after this time will not be eligible for review under the internal appeals procedures.

"Pre-Service" Health Claims

Pre-service health claims are claims for health benefits that require advance approval from the plan.

The Claims Administrator will provide notice of the plan's final decision within 15 days after receipt of the pre-service health claim. However, if the Claims Administrator needs more time to make a determination due to matters beyond its control, the Claims Administrator will notify you or your representative of the need for additional time within 15 days after receiving the claim. This notice will include the reason for the extension and the date a determination can be expected, which will be no more than 30 days after receipt of the claim. If more time is needed because necessary information is missing from the claim, the notice will also specify what information is needed, and you or your representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends such a notice of missing information, and will resume on the date you or your representative responds to the notice.

You or your authorized representative may file a written appeal with the Appeals Administrator for the plan within 180 days after receiving notice of a denied pre-service health claim. (See "Plan Funding and Administration Chart" for the plans' appeals address.) Appeals received after this time will not be eligible for review under the internal appeals procedures.

"Urgent Care" Health Claims

Urgent care health claims are claims for health benefits which if not received (1) could seriously jeopardize your life, health, or ability to regain maximum function or (2) in the opinion of the attending physician, cause you severe pain which cannot be managed without the requested services. If the attending physician determines the claim is an urgent care health claim, the Claims Administrator will treat the claim as an urgent care health claim.

The Claims Administrator will evaluate and respond to urgent care health claims within 72 hours after receiving the urgent care health claim. However, if necessary information is missing from the claim, the Claims Administrator will notify you or your representative within 24 hours after receiving the claim to specify the information that is needed. You or your representative must provide the specified information to the Claims Administrator 48 hours after receiving the notice. The Claims Administrator will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice or within 48 hours after requesting the information, whichever occurs first. Expedited notices of determinations may be provided orally lowed within three (3) days by written or electronic notification.

Upon receiving notice of a denied claim for urgent health benefits, you or your authorized representative may file an expedited appeal with the Appeals Administrator of the applicable plan orally, by phone or by facsimile.

Concurrent Care Health Claims

These are health claims to extend the approval for an ongoing course of treatment that has already been approved. You or your representative must submit a concurrent care health claim to the Claims Administrator at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative submits a concurrent care health claim, the Claims Administrator will notify you or your representative of the determination within 24 hours after receiving the request.

You or your authorized representative may file a written appeal with the Appeals Administrator for the plan within 180 days after receiving notice of a denied concurrent care health claim. Appeals received after this time will not be eligible for review under the internal appeals procedures.

Notification of Denial

If a claim for plan benefits is denied in whole or in part, the Claims Administrator for the applicable plan denying the claim will send you a written notice of the denial. This notice will include (1) the specific reasons for the denial; (2) references to the provisions of the plan on which the denial is based; (3) a description of additional material or information necessary to perfect the claim and an explanation of why the material or information is needed; and (4) an explanation of the procedure to appeal the denial, including the time limit appli le to such procedure, and a statement of your right to bring a civil action under section 502(a) of ERISA if the claim is denied upon review.

In addition to the information required above, a notice denying a claim for health benefits will include the following additional information: (i) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit, (ii) in the case of a health claim involving urgent care, a description of the expedited review process applicable to such claim, and (iii) such other information as the Claims Administrator determines is required by applicable law.

If Your Claim for Benefits Is Denied Under Your HRA

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after OneExchange receives your claim. If OneExchange determines that an extension of this time period is necessary due to matters beyond the control of the Plan, OneExchange will notify you within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified and you will have at least 45 days to provide the additional information. The notice of denial will contain:

- The reason(s) f
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information
- A description of the appeal procedures and the time limits applicable to such procedures and
- A description of your right to request all documentation relevant to your claim.

If your request for reimbursement under the HRA is denied in whole or in part and you do not agree with the decision of OneExchange, you may file a written appeal. Your first level of appeal is with Extend Health, and should be sent to following address (also included on your Explanation of Payment statement):

Towers Watson
P.O. Box 2396
Omaha, NE 68103-2396
Fax: 855-321-2605

If the original claim decision is upheld by OneExchange, you can file a second level of appeal with the IBM Plan Administrator at the address provided (see "Legal Information" on page 209) no later than 180 days after receipt of the first appeal denial notice. You should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim. You will be notified in writing of the decision on appeal no later than 30 days after the IBM Plan Administrator receives your request for appeal. The notice will contain the same type of information provided in the first notice of denial provided by the Claims Submission Agent.

Note that you cannot file suit in federal court until you have exhausted these appeals procedures.

APPEALS

If your claim for benefits is denied, in whole or in part, you have the right to appeal the denial. An authorized representative may file the appeal on your behalf. There is only one level of appeal for denials of (1) urgent care health claims and (2) claims that are not for health benefits. IBM has a two-step internal appeals procedure for denials of health claims that are not urgent care health claims.

If your claim is subject to two levels of appeal, (1) the level-one appeal follows your initial claim denial and the level-two appeal follows the level-one appellate decision, and (2) except for claims under SCCAP, you must exhaust both levels of appeal before you have a right to bring a civil action. For claims under SCCAP you must exhaust only the level-one appeal before you have a right to bring a civil action.

The level-one appeal (or the appeal for claims that are entitled to only one appellate review) will be administered by the Appeals Administrator for the applicable plan. (See "Plan Funding and Administration Chart" for the plans' appeals addresses.) The le l be administered by the IBM Plan Administrator.

For those enrolled in a plan option through OneExchange, level one appeals regarding HRA claim denials or other HRA-related disputes will be handled by OneExchange. The level-two HRA claim appeal will be administered by the IBM Plan Administrator. Appeal instructions will be sent to you by OneExchange. For all other appeals, those should be directed to the health plan in which you are enrolled.

Filing An Appeal

A request for appeal must be filed with the Appeals Administrator or the IBM Plan Administrator, as applicable. Except as described in the following paragraph for appeals regarding urgent care health claims, the request for appeal must be in writing and include the reason why you feel your claim should be approved, any information supporting your appeal, and any information required by the Appeals Administrator or the IBM Plan Administrator, as applicable. You may submit written comments, documents, records, and other information relating to the claim. The Claims Administrator or Appeals Administrator, as applicable, will provide you, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

You may submit an oral or written request for an expedited appeal of a denial of an urgent care health claim. For an expedited appeal of an urgent care health claim, all necessary information will be transmitted between you and the Appeals Administrator by telephone, facsimile lectronic mail, or other available similarly expeditious methods.

Deadline for Filing An Appeal

An appeal for a claim denial for benefits other than health benefits must be filed within 60 days after you or your authorized representative receives notice of the initial claim denial. For an appeal related to a claim for health benefits, the 60-day period will be extended to 180 days. If you (or your authorized representative) f

Appeal for Denial of Non-Health Benefits

For appeals for benefits that are not health benefits, unless special circumstances require an extension of time for processing the appeal, the Appeals Administrator will notify you or your authorized representative of its decision within 60 days after the Appeals Administrator receives the written request for appeal. If an extension is necessary, the Appeals Administrator will notify you or your authorized representative before the expiration of the initial 60-day period. The notice will indicate the circumstances requiring the extension and the date by which the Appeals Administrator expects to render a decision. In no event may the extension exceed 60 days from the end of the initial period.

Appeal for Denial of Health Benefits

Post-Service Health Appeals

The Appeals Administrator will respond in writing with a decision within 30 calendar days after it receives an appeal for a post-service health claim determination. After receiving notice of a denied post-service health claim on appeal, you or your authorized representative may file a written appeal with the IBM Plan Administrator within 180 days. Notification of the final decision by the IBM Plan Administrator will be provided within 30 calendar days after it receives the request for appeal.

Pre-Service Health Appeals

The Appeals Administrator will respond in writing with a decision within 15 calendar days after it receives an appeal for a required pre-service health claim. After receiving notice of a denied pre-service health claim on appeal, you or your authorized representative may file a written appeal with the IBM Plan Administrator within 180 days. Notification of the final decision by the IBM Plan Administrator will be provided within 15 days after receipt of the request for appeal.

Urgent-Care Health Appeals

The Appeals Administrator will respond orally to an appeal of an urgent care health claim with a decision within 72 hours, followed up in writing. This is the final step in IBM's internal appeals process for urgent care health claims.

Concurrent Care Appeal

An appeal of a concurrent care health claim denial will be classified as either an urgent care health claim, a post-service health claim, or a pre-service health claim, depending on the nature of the claim. Based on this classification, the applicable deadlines described above for urgent care health claims, post-service health claims, or pre-service health claims will apply to the concurrent claim appeal.

Procedures for Making Decision on Appeal

A decision on appeal will take into account all comments, documents, records, and other information submitted by you or your authorized representative relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination or level-one appeal decision. The Appeals Administrator's or IBM Plan Administrator's, as applicable laim will not afford deference to the initial claim denial decision or any level-one appeal decision and will be made by someone who was not involved in the initial claim decision.

If the plan has denied an appeal for health benefits based on a medical judgment (e.g., m l/in l), the Appeals Administrator or IBM Plan Administrator, as applicable ll consult with a health care professional with appropriate training and experience in the relevant field, who is not the individual who was consulted in connection with the initial claim denial or level-one decision regarding the claim or a subordinate of such individual. In this case, you may be asked to complete a Release of Information (ROI) allowing the health care professional to review your medical records and contact your physician.

By filing an appeal for health benefits with the IBM Plan Administrator (or, as a result of a filing on your behalf by your authorized representative), you acknowledge that the IBM Plan Administrator may receive and use information from the applicable plans related to your claim for benefits, for purposes of reviewing and rendering a decision on your appeal. The Health Insurance Portability and Accountability Act (HIPAA) rules will apply to the IBM Plan Administrator's use of such information (see "Your Rights Under HIPAA").

Effect of Decision on Appeal

The decision of the Appeals Administrator for (1) urgent care health claims, (2) claims that are not for health benefits, and (3) appeals for benefits under SCCAP (if you choose not to pursue a level-two appeal for your SCCAP claim), is final and binding on all parties, including you and any of your beneficiaries under the plan. The decision of the IBM Plan Administrator for non-urgent care appeals or voluntary level-two appeals for benefits under SCCAP is final and binding on all parties, including you and any of your beneficiaries under the plan.

Notification of Determination on Appeal

If an appeal for plan benefits is denied in whole or in part, the Appeals Administrator for the applicable plan deciding a single level or level-one appeal or the IBM Plan Administrator deciding a level-two appeal will send you a written notice of its determination. This notice will include (1) the specific reasons for the decision, (2) references to the provisions of the plan on which the decision is based, (3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits, and (4) a statement that you might have a right to bring a civil action under section 502(a) of ERISA after exhaustion of the final appeal.

In addition to the information required above, a notice denying an appeal for health benefits will include the following additional information: (i) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit, (ii) if required under section 503 of ERISA, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and our state insurance regulatory agency," and (iii) such other information as the Appeals Administrator or IBM Plan Administrator determines is required by applicable law.

Legal Action

Subject to the limitations described in the "Time Limit on Commencing Litigation and Forum for Litigation" section, below, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the internal appeals process. Before bringing an action, you generally must have submitted both a level-one and level-two appeal f lth claims and a level-one appeal for urgent care health claims and claims under SCCAP. However, if the Claims Administrator, Appeals Administrator, or IBM Plan Administrator fails to follow the internal claims and appeals procedures, in certain circumstances you will be deemed to have exhausted the internal claims and appeals process before receiving a final decision on appeal. If you believe such a failure has occurred, within 60 days of the failure you must notify the administrator your health claims and you may request an explanation of whether the violation is insignificant or otherwise would not result in a deemed exhaustion of the internal claims and appeals procedures.

The plan may also offer you other voluntary alternative dispute resolution options, such as mediation.

Time Limit on Commencing Litigation and Forum for Litigation

No Applicable Claim (as defined in Paragraph (A), below) may be filed in any court or in any other forum until you have exhausted the claims procedures described in the "Claims and Appeals" sections. An Applicable Claim must be filed in a court described in Paragraph (B), below, within the Applicable Limitations Period prescribed by Paragraphs (C) and (D), below. No Applicable Claim may be filed after the Applicable Limitations Period.

(A) An "Applicable Claim" is:
- (1) a claim or action to recover benefits allegedly due under the provisions of a plan or plan option covered under this book (hereinafter, a "Plan") or by reason of any law
- (2) a claim or action to clarify rights to future benefits under the terms of a Plan
- (3) a claim or action to enforce rights under a Plan or

(4) any other claim or action brought by a person who is, seeks to be, or is a successor to a current or former (I) employee (within the meaning of ERISA section 3(6)) of the Company, (II) participant (within the meaning of ERISA section 3(7)), or (III) beneficiary (within the meaning of ERISA section 3(8)) that—
   (a) relates to a Plan and
   (b) seeks a remedy, ruling, or judgment of any kind against a Plan, the Plan Administrator, the Company, or a fiduciary (within the meaning of ERISA section 3(21)) or a party in interest (within the meaning of ERISA section 3(14)) with respect to the Plan.

(B) A court described in this Paragraph (B) includes one of the following courts:
   (1) the United States District Court for the district in which the Plan is principally administered, which is currently New York State
   (2) in the case of an action brought by an individual plaintiff, the United States District Court for the district in which the plaintiff resides or
   (3) in the case of an action brought by more than one plaintiff, the United States District Court for the district in which the largest number of plaintiffs (or in the case of a putative class action, the district in which the largest number of putative class members) reside (or if that district cannot be determined, the district in which the largest number of class members is reasonably believed to reside).

If an Applicable Claim is filed in a court other than a court described in this Paragraph (B), the Plan, all parties to such action that are related to the Plan (such as Plan fiduciaries, administrators, or parties in interest), and the alleged Plan participants and beneficiaries must take all necessary steps to have the action removed to, transferred to, or re-filed in a court described in this Paragraph (B). This Paragraph (B) is waived if no party invokes it within 120 days of the filing of a putative class action or the assertion of class action allegations.

(C) The "Applicable Limitations Period" for any Applicable Claim will begin on the following date (the "Limitations Start Date"):
   (1) In the case of an Applicable Claim to recover benefits allegedly due under the Plan or to clarify rights to future benefits from the Plan, the earliest of (I) the date the first benefit payment was actually made, (II) the date the first benefit payment was allegedly due, or (III) the date the Company, the Plan, or the Plan Administrator first repudiated the alleged obligation to provide such benefits. A repudiation described in clause (III) may be made in the form of a direct communication to you or your beneficiary (*e.g.*, a denial of a claim under administrative review as described in the "Claim and Appeals" sections) or a more general oral or written communication related to benefits payable under the Plan (for example, the SPD, a benefit statement, or an agreement).
   (2) In the case of any other Applicable Claim, the earliest date on which you or your beneficiary, if applicable, k
, regardless of whether you or your beneficiary was aware of the legal theory underlying the Applicable Claim.

(D) The Applicable Limitations Period for any Applicable Claim will end on the second anniversary of the Limitations Start Date for such Applicable Claim; provided, however, that:
   (1) if a request for administrative review pursuant to the "Claims and Appeals" sections is pending when the Applicable Limitations Period expires, the deadline for filing such Applicable Claim shall be extended to the date that is 60 calendar days after the final denial (including a deemed denial) of such claim on administrative review and
   (2) if paragraph (C)(2), above, applies, the Applicable Limitations Period shall end no later than six years after (i) the date the last action on which such claim or action is based or (ii) in the case of an omission, the latest date on which such omission could have been cured, without regard to whether you or your beneficiary know or should have known the material facts on which the claim or action is based.

(E) The Applicable Limitations Period replaces and supersedes any limitations period that otherwise might be deemed applicable under state or federal law in the absence of this Section ("Time Limit on Commencing Litigation and Forum for Litigation"). A claim or action filed after the expiration of the Applicable Limitations Period shall be deemed time-barred, except that:

(1) The Plan Administrator has discretion to extend the Applicable Limitations Period upon a showing of exceptional circumstances that, in the opinion of the Plan Administrator, provide good cause for an extension. The exercise of this discretion is committed solely to the Plan Administrator, and is not subject to review.

(2) The Applicable Limitations Period will apply to a claim governed by section 413 of ERISA only to the extent permitted by law.

(F) In the event an Applicable Claim is brought by or on behalf of two or more claimants, the requirements of this Section ("Time Limit on Commencing Litigation and Forum for Litigation") will apply separately with respect to each claimant.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

If not otherwise provided for herein, the IBM Medical and Dental Benefits Plan for Retired Employees shall provide coverage to a child solely to the extent required by a qualified medical child support order under ERISA section 609(a) or to an adoptive child solely to the extent required by ERISA section 609(c). Further, the Plan shall be interpreted and administered as necessary to comply with the requirements of ERISA section 609. Any coverage provided as a result of a qualified medical child support order shall be conditioned on payment of required contributions, if any, by or with respect to you.

Federal law requires that a child support notice, judgment, or order must meet certain form and content requirements to be a QMCSO. The Plan Administrator follows certain procedures to determine if a child support notice, judgment, or order meets these requirements. You may request a copy of these procedures at no charge. If you have any questions or would like a copy of the QMCSO administrative procedures, please contact the ESC.

FEDERAL LAWS

The IBM Benefits Plan for Retired Employees shall be interpreted and administered in accordance with the intent to comply with the applicable requirements of the Newborns' and Mothers' Health Protection Act of 1996 and the Genetic Information Nondiscrimination Act of 2008 ("GINA"), each as amended. If the Plan Administrator determines that any provision of the Plan or an Incorporated Document does not comply with a requirement described in the immediately preceding sentence, such provision shall be deemed to be reformed in a manner that the Plan Administrator determines (A) reasonably effectuates the intent of such provision and (B) is consistent with the applicable law. For the avoidance of doubt, the decision of whether reformation is required by this section and the extent of any such reformation shall be made by the Plan Administrator and not by any court, arbitrator, regulator, or other individual or entity.

The IBM Benefits Plan for Retired Employees does not cover any active employees. Accordingly, the Plan is not subject to (i) the special enrollment, pre-existing condition, and nondiscrimination requirements (other than those relating to GINA) of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"); (ii) the Women's Health and Cancer Rights Act of 1998, as amended, with respect to post-mastectomy reconstructive surgery; (iii) the Mental Health Parity Act of 1996, as amended, or the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, with respect to mental health benefits; or (i) the coverage mandates and prohibitions for group health plans under the Patient Protection and Affordable Care Act, as amended ("PPACA").

YOUR RIGHTS UNDER ERISA

On September 2, 1974, the Employee Retirement Income Security Act of 1974 ("ERISA") was enacted, establishing federal controls over most employee pension and welfare benefit Plans. As a participant in the plans covered in this book, you are entitled to certain rights and protections under ERISA.

Receive Information About Your Plan and Benefits

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and the latest annual report (Form 5500 series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report for plans that are required to have such a report. The Plan Administrator is required by law to furnish each participant with a copy of this annual summary report for plans that are required to have such a report.

Continue Group Health Care

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plans covered in this book which are governed by ERISA. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a welfare benefit is ignored or denied, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules. You cannot sell, transfer or assign the value of your benefit under the health plan.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is ignored or denied, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order (QMSCO), you may file suit in federal court.

If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration at:

Division of Technical Assistance and Inquiries, Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

It is anticipated that most questions can be answered by the ESC.

YOUR RIGHTS UNDER NMHPA

The Newborns' and Mothers' Health Protection Act provides that group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that provider to obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

YOUR RIGHTS UNDER WHCRA

The Women's Health and Cancer Rights Act (WHCRA) requires that all group health plans that provide medical and surgical benefits with respect to a mastectomy to provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema.

These services must be provided in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to annual deductibles, copayments and coinsurance provisions applicable to other such medical and surgical benefits provided under the applicable IBM Medical Plan option. Please refer to the applicable At-A-Glance chart for information regarding deductibles, copayments and coinsurance under the IBM Medical Plan option in which you are enrolled.

For information regarding the HMO options, please contact the HMO directly. If you would like more information on the Women's Health and Cancer Rights Act benefits, call the ESC.

YOUR RIGHTS UNDER USERRA

If you are serving in the military and are covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you will continue to participate and be eligible to receive benefits under the Plan in accordance with USERRA rules and regulations.

PLAN DISCLOSURE INFORMATION

ERISA also requires companies to disclose certain detailed information to you so that you have it available for reference purposes. If you need additional information, you are encouraged to call the ESC. If you have questions regarding coverage and claim payments, you can obtain more information from the individual Claim Administrators.

Plan Year

The records of all of the plans covered in this book are kept on a calendar-year basis, beginning January 1st and ending December 31st of each year, which is in each case, the plan year.

Plan Documents

This summary plan description is intended merely as a summary of the official plan document(s). The official plan documents are the final authority and shall govern in all cases. The Plan Administrator retains exclusive authority and discretion to interpret the terms of the benefits plans described herein.

Plan Sponsor

The Plans covered in this summary plan description are sponsored and maintained by the IBM Corporation. The Plans covered in this book have been established by IBM Corporation, Armonk, NY. The Employer Identification Number (EIN) assigned to IBM is #13-0871985.

Plan Administrator

The Plan Administrator for the IBM Medical and Dental Benefit Plans for Retired Employees is a committee which consists of three or more executive level employees appointed by action of the IBM Retirement Plans Committee. The address for the Plan Administrator is:

Office of the Plan Administrator
IBM Employee Services Center
PO Box 770003
Cincinnati, OH 45277-1060

Telephone: 800-796-9876 (TTY: 800-426-6537); outside the U.S. call 919-784-8646.

Agent for Service of Legal Process

Service of legal process may be made upon the Plan Administrator.

Plan Funding and Administration

The Plan is self-funded and regulated by federal law. The role of the insurance companies that administer the individual medical, dental and vision options within the Plan is not to insure the Plan but to provide administrative services under contracts with IBM. These companies are referred to in this document as "health plan," "medical plan", "dental plan" or "contract administrator." Eligibility for coverage of dependents, health care providers, facilities and treatments and supplies is determined solely by the provisions of the IBM Benefits Plan for Retired Employees. State or local laws mandating coverage for certain dependents, providers, f lities, treatments, etc., do not apply to the Plan. Final discretion and authority to interpret the provisions of the Plan rest with the Plan Administrator.

Trustee for the IBM Medical and Dental Benefit Plans for Regular Full-Time and Part-Time Employees

The Plan trustee is:

JPMorgan Chase Bank
4 New York Plaza, 17th Floor
New York, NY 10004

RIGHT TO MODIFY OR TERMINATE IBM BENEFIT PLANS

IBM reserves the right, at its discretion, to amend, change or terminate any of its benefits plans, programs, practices or policies, as the Company requires. Nothing contained in this book shall be construed as creating an express or implied obligation on the part of IBM to maintain such benefits plans, programs, practices or policies.

IBM's benefit plans may be amended by written resolution of the Board of Directors or any Committee to which the Board has delegated power. The Retirement Plans Committee is authorized to amend any plan which is funded through a trust, including the IBM Plan. All other benefit plans may be amended by the IBM chief human resources officer or other IBM executive by means of a written instrument, such as the text of a plan, a summary plan description, a trust agreement, an insurance contract or insurance certificate, an administrative services contract, the administrative documents and procedures for a plan, an electronic medium notice, a hard copy bulletin board notice or an announcement letter or written materials that are approved by said chief human resources officer or other IBM executive and maintained with the records of the affected benefit plan.

PLAN FUNDING AND ADMINISTRATION CHART

Official Plan Name and Type	Plan Number	Type of Administration	Benefits Type	Claims Administrator	Funding
Plan Name: IBM Benefits Plan for Retired Employees Plan Type: Medical, Dental	518	Plan Administration and Contract Administration	▪ IBM Low, Medium and High Deductible PPO ▪ IBM EPO ▪ IBM High Deductible with HSA	Anthem Blue Cross and Blue Shield P.O. Box 105568 Atlanta, GA 30348 MVP Select Care, Inc. Attn: Member Appeals P.O. Box 2207 Schenectady, NY 12301 Aetna, Inc. P.O. Box 981107 El Paso, TX 79998-1107 UnitedHealthcare Insurance Company P.O. Box 740816 Atlanta, GA 30374-0816	Self-insured by IBM and funded by employer and employee contributions based on actual valuations
			▪ IBM Out-of-Area options	UnitedHealthcare Insurance Company P.O. Box 740816 Atlanta, GA 30374-0816	
			▪ Aetna Medicare Plan (HMO) ▪ Aetna Medicare Plan (PPO)	Aetna Claims Address: P.O. Box 981106 El Paso, TX 79998 Appeals Address: P.O. Box 14663 Lexington, KY 40512 Pharmacy Claims Commercial APM Claims P.O. Box 14024 Lexington, KY 40512-4024	
			IBM Vision Plan	Anthem BlueView Vision ATTN: OON Claims P.O. Box 8504 Mason, OH 45040-7111	Fully Insured
			HMOs	Various	Fully Insured

Official Plan Name and Type	Plan Number	Type of Administration	Benefits Type	Claims Administrator	Funding
			Managed Mental Health Care Program	Optum-Health	
			IBM Managed Pharmacy Program	CVS Pharmacy	Fully Insured
			Dental Options A and B MetLife PDP Dental Plus and Dental Basic	Metropolitan Life Insurance Company P.O. Box 981282 El Paso, TX 79998	Various -- Fully Insured
			Health Reimbursement Arrangement (HRA) IBM Supplemental Prescription Drug Benefit	Towers Watson 10975 South Sterling View Drive Suite A-1 South Jordan, UT 84905 (855)359-7380 www.extendhealth.com/ibm	
			IBM Supplemental Medical Benefit	UnitedHealthcare Insurance Company P.O. Box 740816 Atlanta, GA 30374-0816	
Plan Name: IBM Special Care for Children Assistance Plan Plan Type: Special Care	508	Plan Administration and Contract Administration	Special Care for Children Assistance Plan	Anthem Blue Cross and Blue Shield P.O. Box 5012 Middletown, NY 10940-9021	Self-insured by IBM with no employee contributions
Plan Name: Special Health Assistance Provision (SHAP)		Plan Administration and Contract Administration	Special Health Assistance Provision (SHAP)	Acclaris P.O. Box 25171 Lehigh Valley, PA 18002-5171	Benefits are paid from Company's general assets.
Plan Name: Life Planning Account Plan Type: Wellness Programs	526	Contract Administration	Life Planning Account	Acclaris P.O. Box 25171 Lehigh Valley, PA 18002-5171	Benefits are paid from Company's general assets.
Plan Name: IBM Adoption Assistance Plan Plan Type: Special Care	521	Contract Administration	Adoption Assistance	Acclaris P.O. Box 25171 Lehigh Valley, PA 18002-5171	Benefits are paid from Company's general assets.

Official Plan Name and Type	Plan Number	Type of Administration	Benefits Type	Claims Administrator	Funding
Plan Name: IBM Group Life Insurance Plan Type: Special Care	501	Insurance policy	Life Insurance	The Prudential Insurance Company of America Trustee: IBM Corporation and The Prudential Insurance Company of America	Insured